CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the recipient.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Monthly fee for service with cost settlement. Providers of MR/CMI/DD case management services are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in an MR/CMI/DD case management program for any portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

Providers are reimbursed throughout each fiscal year on the basis of a projected monthly rate for each participating provider, based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles) with annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on financial and statistical reports. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

The methodology for determining the reasonable and proper cost for service provision assumes the following:

(1) The indirect administrative costs shall be limited to 20 percent of other costs.

(2) Mileage shall be reimbursed at a rate no greater than the state employee rate.

(3) The rates a provider may charge are subject to limits established at 79.1(2).

(4) Costs of operation shall include only those costs which pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation, subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospital providers are reimbursed prospectively on a DRG basis for inpatient care and an APG basis for outpatient care, pursuant to subrule 79.1(5), with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients (excluding recipients in managed care), determined in accordance with Medicare cost principles, and the Medicaid fee-for-service reimbursement received on the DRG and APG basis. Amounts paid prior to adjustment that exceed reasonable costs shall be recovered by the department. The base rate upon which the DRG and APG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing covered services to eligible fee-for-service Medicaid recipients for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audits and rate-setting unit and Medicare cost principles.

Once a hospital begins receiving reimbursement as a critical access hospital, prospective DRG and APG payments are not subject to the inflation factors, rebasing, or recalibration as provided in 441—paragraph 79.1(5)*"k"* and 441—paragraph 79.1(16)*"j."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/06 plus 3%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/06 plus 3%. Air ambulance: A base rate of $209.54 plus $7.85 per mile for each mile the patient is carried.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/06 plus 3%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 6/30/06 plus 3%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/06 plus 3%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/06 plus 3%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/06 plus 3%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/06 plus 3%.

Provider category	Basis of reimbursement	Upper limit
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/06 plus 3%.
Federally qualified health centers	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $21.90 per half day, $43.59 per full day, or $65.38 per extended day if no Veterans Administration contract. For mental retardation waiver: County contract rate or, in the absence of a contract rate, $29.18 per half day, $58.25 per full day, or $74.26 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $49.04. Ongoing monthly fee $38.14.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Maximum Medicare rate in effect 6/30/06 plus 3%. For mental retardation waiver: Maximum Medicare rate in effect 6/30/06 plus 3% converted to an hourly rate.

Provider category	Basis of reimbursement	Upper limit
4. Homemakers	Fee schedule	Maximum of $19.61 per hour.
5. Nursing care	For elderly and mental retardation waivers: Fee schedule as determined by Medicare.	For elderly waiver: $82.10 per visit. For mental retardation waiver: Maximum Medicare rate in effect 6/30/06 plus 3% converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $82.10 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate in effect 6/30/06 plus 3% converted to an hourly rate not to exceed $294 per day.
Basic individual respite	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate in effect 6/30/06 plus 3% converted to an hourly rate not to exceed $294 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.99 per hour not to exceed $294 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.42 per hour not to exceed $294 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.83 per hour not to exceed $294 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.99 per hour not to exceed $294 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.42 per hour not to exceed $294 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$17.83 per hour not to exceed $294 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$12.99 per hour not to exceed $294 per day.

Provider category	Basis of reimbursement	Upper limit
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$12.99 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$12.99 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$12.99 per hour not to exceed $294 per day.
Adult day care	Fee schedule	$12.99 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$12.99 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$12.99 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$12.99 per hour not to exceed daily per diem rate for rehabilitative treatment and supportive services.
Child care facilities	Fee schedule	$12.99 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.63 per half hour.
8. Home-delivered meals	Fee schedule	$7.63 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1000 lifetime maximum. For mental retardation waiver: $5,000 lifetime maximum. For brain injury, ill and handicapped, and physical disability waivers: $6,000 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.17 per unit.
13. Assistive devices	Fee schedule	$108.96 per unit.
14. Senior companion	Fee schedule	$6.53 per hour.

Provider category	Basis of reimbursement	Upper limit
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$19.61 per hour not to exceed the daily rate of $113.32 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,052 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $35.64 per day.
Individual	Fee agreed upon by consumer and provider	$13.08 per hour not to exceed the daily rate of $76.28 per day.
16. Counseling		
Individual:	Fee schedule	$10.68 per unit.
Group:	Fee schedule	$42.71 per hour.
17. Case management	Fee schedule	For brain injury waiver: $592.75 per month. For elderly waiver: $70 per month.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.63 per hour, $78.10 per day not to exceed the maximum daily ICF/MR per diem.
19. Supported employment:		
Activities to obtain a job	Fee schedule	$500 per unit not to exceed $1,500 per calendar year.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.63 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.61 per hour for personal care. Maximum of $6.13 per hour for services in an enclave setting. Total not to exceed $2,855.16 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6,000 per year.
21. Behavioral programming	Fee schedule	$10.68 per 15 minutes.
22. Family counseling and training	Fee schedule	$42.71 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $37.07 per day. For the mental retardation waiver: County contract rate or, in absence of a contract rate, $47.74 per day.

Provider category	Basis of reimbursement	Upper limit
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Rate for home health aide services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate in effect 6/30/06 plus 3% converted to an hourly rate.
Home health agency (provided by nurse)	Rate for nursing services provided by a home health agency (encounter services-intermittent services)	Maximum Medicare rate in effect 6/30/06 plus 3% converted to an hourly rate.
Child development home or center	Fee schedule	$12.99 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $13.08 per hour, $31.83 per half day, or $63.65 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6,000 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.63 per hour.
29. In-home family therapy	Fee schedule	$92.70 per hour.
30. Financial management services	Fee schedule	$65 per enrolled consumer per month.
31. Independent support broker	Rate negotiated by consumer	$15 per hour.
32. Self-directed personal care	Rate negotiated by consumer	Determined by consumer's individual budget.
33. Self-directed community supports and employment	Rate negotiated by consumer	Determined by consumer's individual budget.
34. Individual-directed goods and services	Rate negotiated by consumer	Determined by consumer's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/06 plus 3%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule based on MR/CMI/DD case management rates as set under 79.1(1)*"d."*	$592.75 per month.

Provider category	Basis of reimbursement	Upper limit
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.24 per hour or $104.92 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.08 per hour, $31.83 per half-day, or $63.65 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.81 per hour, $23.87 per half-day, or $47.74 per day.
5. Supported employment:		
Activities to obtain a job	Retrospective cost-related. See 79.1(24)	$500 per job, not to exceed $1,500 per year.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.13 per hour for services in an enclave setting; $19.61 per hour for personal care; and $34.63 per hour for all other services. Total not to exceed $2,855.16 per month. Maximum of 40 units per week.
Home health agencies (Encounter services-intermittent services)	Retrospective cost-related	Rate in effect 6/30/06 plus 3%.
(Private duty nursing or personal care and VFC vaccine administration for persons aged 20 and under)	Interim fee schedule with retrospective cost settling based on Medicare methodology	Rate in effect 6/30/06 plus 3%.